

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12394

CERTIFICATE OF DEATH

12381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithville Road				e. STREET ADDRESS Smithville Road			
3. NAME OF DECEASED (Type or print) Anthony Dorman				4. DATE OF DEATH Month November Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1911		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics, Inc.		11. BIRTHPLACE (State or foreign country) Sanderson, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerry Dorman				14. MOTHER'S MAIDEN NAME Ellen (maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-6880		17. INFORMANT Mrs. Miriam F. Dorman, Federalsburg, Md., R.ED			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6/1/54 19 54 , to 11/20 19 59 , that I last saw the deceased alive on 11/20 19 59 , and that death occurred at 4 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 11-21-59							
ACTUAL SIGNATURE Frank M. Anderson		PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 22, 1959	22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frempton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2452

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12382

12395

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>RIDGELEY</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELEY MARYLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>FRED</u> First <u>H.</u> Middle <u>FLOUNDERS</u> Last				4. DATE OF DEATH <u>Nov</u> Month <u>20</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1875</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK OF CANNING HOUSE</u>				11. BIRTHPLACE (State or foreign country) <u>QUEEN ANN Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD CARTEP FLOUNDERS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Fred Flounders</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the mouth & throat</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive leukoplakia of the mouth</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 15</u> , 19 <u>59</u> , to <u>Nov. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 20</u> , 19 <u>59</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>Nov. 21, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>Nov 22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENSBORO</u>		22d. LOCATION (City, town, or county) (State) <u>GREENSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u> ADDRESS <u>Sentow, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12383

Reg. Dist. No.

12396

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely				c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alpheus First Alexander Middle Horney, Sr. Last				4. DATE OF DEATH November Month 7 Day 19 Year 59			
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1876	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alpheus Horney				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 040-20-0523		17. INFORMANT Alpheus Horney Address West Haven, Conn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart 420.0 DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May , 19 54 , to Nov. 7 , 19 59 , that I last saw the deceased alive on Nov. 7 , 19 59 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ridgely, Md DATE SIGNED 11/7/59 ACTUAL SIGNATURE Charles H. Winnacott M.D. Ridgely, Md PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-10-59 22c. NAME OF CEMETERY OR CREMATORY Hillsboro Greenmount Hillsboro, Maryland 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE Raymond B Rawlings ADDRESS Brown bro md 24a. REC'D BY REGISTRAR NOV 10 '59 24b. REGISTRAR'S SIGNATURE William S. House							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
1935

CERTIFICATE OF DEATH

NAME OF DECEASED Alexander, Robert, Sr.		DATE OF DEATH November 27, 1935	
PLACE OF DEATH Home		CITY OF DEATH Baltimore	
AGE 57		SEX Male	
RACE White		RELIGION Roman Catholic	
MARRIAGE Married		EDUCATION High School	
OCCUPATION None		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		IMMEDIATE CAUSE OF DEATH Myocardial Infarction	
DISEASE OR INJURY None		PERMANENT CAUSE OF DEATH None	
SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		SIGNATURE OF REGISTRAR J. Edgar Smith, M.D.	
DATE OF SIGNATURE November 27, 1935		DATE OF SIGNATURE November 27, 1935	

12397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro				c. LENGTH OF STAY IN TB 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro			
f. STREET ADDRESS None				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert Hudson				4. DATE OF DEATH Month Day Year November 18 19 59			
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-1879	
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min. 79		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Hudson				14. MOTHER'S MAIDEN NAME Louise Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-36-0922		17. INFORMANT Address Altha Hudson Goldsboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Prostate with metastasis to the hips DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia (nutritional)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 12, 1959 , to Nov. 18, 1959 , that I last saw the deceased alive on Nov. 17, 1959 , and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 11/19/59							
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.				PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleais, Greensboro, Md.				24a. REC'D BY REGISTRAR DATE NOV 23 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12385

12398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle Davis Last Jefferson		4. DATE OF DEATH Month November Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1867
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward F. Davis		14. MOTHER'S MAIDEN NAME Laura Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Donald E. Jefferson, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General carcinomatosis 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of liver DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 mos. 9 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 to Nov. 20 , 19 59 , that I last saw the deceased alive on Nov. 20 , 19 59 , and that death occurred at 7:30P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Maryland DATE SIGNED 11-23-59 ACTUAL SIGNATURE W. K. Knotts M.D. PHYSICIAN'S NAME (Type) W. K. Knotts, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Page One of One

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>1910-01-01</u></p>		<p>4. Age: <u>35</u></p>	
<p>5. Place of Birth: <u>New York City</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Usual Residence: <u>123 Main St, Baltimore, Md</u></p>		<p>8. Date of Death: <u>1945-03-15</u></p>	
<p>9. Time of Death: <u>10:30 AM</u></p>		<p>10. Cause of Death: <u>Heart Disease</u></p>	
<p>11. Immediate Cause: <u>Myocardial Infarction</u></p>		<p>12. Underlying Cause: <u>Coronary Artery Disease</u></p>	
<p>13. Contributing Cause: <u>None</u></p>		<p>14. Manner of Death: <u>Natural</u></p>	
<p>15. Physician's Name: <u>Dr. J. Smith</u></p>		<p>16. Signature of Physician: <u>[Signature]</u></p>	
<p>17. Date of Certificate: <u>1945-03-16</u></p>		<p>18. Registrar's Name: <u>John Doe</u></p>	
<p>19. Signature of Registrar: <u>[Signature]</u></p>		<p>20. Date of Registration: <u>1945-03-16</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12386**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CAROLINE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely c. LENGTH OF STAY IN life life			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Rt 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Matthew First Johns Middle Johns Last			4. DATE OF DEATH Month 11 Day 19 Year 1959		
5. SEX Male		6. COLOR OR RACE Gal		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/12/1899		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY Farmer owner		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Moses Johns			14. MOTHER'S MAIDEN NAME Leah Hutchins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Corie Johns, Ridgely Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (c) ? DUE TO cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 1/2 -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dawson D. George			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) DAWSON D. GEORGE			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 11-20-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORY Congress Cem	
22d. LOCATION (City, town, or county) Denton		(State) Md.		23. FUNERAL DIRECTOR'S SIGNATURE James B. Collier, Denton, Md.	
24a. REC'D BY REGISTRAR DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12387

12400

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last AGNES EMMA LANE				4. DATE OF DEATH Month Day Year Nov. 11 19 59			
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6-1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN GAITLEY				14. MOTHER'S MAIDEN NAME ALICE BRIGHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT FRANK LANE				Address RIDGELY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis (c) Arteriosclerosis - Hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours - Several yrs - Several yrs -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April - , 19 50 , to Nov. 11 , 19 59 , that I last saw the deceased alive on Nov. 11 , 19 59 , and that death occurred at 9 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Winnacott				ADDRESS (Street, city or town, state) Ridgely, Md			
M.D. Ridgely, Md				DATE SIGNED 11/14/59			
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 14		22c. NAME OF CEMETERY OR CREMATORY CENTREVILLE		22d. LOCATION (City, town, or county) (State) CENTREVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN WHITE		2. SEX Male		3. AGE 65		4. DATE OF BIRTH June 6, 1888		5. PLACE OF BIRTH MD	
6. OCCUPATION None		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION None		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH June 10, 1954		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease	
16. MEDICAL HISTORY None		17. PRESENT ILLNESS None		18. TREATMENT None		19. SIGNATURE OF PHYSICIAN None		20. SIGNATURE OF DEATH REGISTRAR None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF WITNESS None		24. SIGNATURE OF DEATH REGISTRAR None		25. SIGNATURE OF DEATH REGISTRAR None	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE OUT IN THE CASE OF EVERY PERSON WHO DIES IN THIS STATE, WHETHER OR NOT THE DECEASED WAS A RESIDENT OF THIS STATE AT THE TIME OF DEATH. IT IS TO BE MADE OUT IN THE CASE OF EVERY PERSON WHO DIES IN THIS STATE, WHETHER OR NOT THE DECEASED WAS A RESIDENT OF THIS STATE AT THE TIME OF DEATH. IT IS TO BE MADE OUT IN THE CASE OF EVERY PERSON WHO DIES IN THIS STATE, WHETHER OR NOT THE DECEASED WAS A RESIDENT OF THIS STATE AT THE TIME OF DEATH.

CERTIFICATE OF DEATH

Reg. Dist. No.

12388

12401

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hickman		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olen T. Middle Melvin Last 		4. DATE OF DEATH Nov. 2, 1959 Month Nov. Day 2 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1884
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store manager- factory work		10b. KIND OF BUSINESS OR INDUSTRY Hickman, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Melvin		14. MOTHER'S MAIDEN NAME Cecelia Noble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Mrs. Bessie Melvin Denton, Md. RFD	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 29, 1959 to Nov. 2, 1959 that I last saw the deceased alive on Nov. 2, 1959 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Metzler, Jr. M.D.		ADDRESS (Street, city or town, state) Main + Market Sts., Bridgeville, Delaware	
PHYSICIAN'S NAME (Type) G. Metzler, Jr. M.D.		DATE SIGNED Arthur S. Kras	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/5/1959	
22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Shannon S. Williams		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kras	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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12402

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12389

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 3 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Mae Patrick				4. DATE OF DEATH Month Day Year 11 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-10-1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Hickson				14. MOTHER'S MAIDEN NAME ? Neighbors			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Medford J. Benney Centerville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Dts. with hypertension (c) General Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1, 1958 , to Nov. 19, 1959 , that I last saw the deceased alive on Nov. 18, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED Nov. 20 '59							
ACTUAL SIGNATURE Charles H. Stonesifer M.D.							
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59		22c. NAME OF CEMETERY OR CREMATORY Chesterfield		22d. LOCATION (City, town, or county) (State) Centerville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleis ADDRESS Greensboro, Md.				24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

<p>1. NAME OF DECEASED James L. Thompson</p>		<p>2. SEX Male</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH 1910</p>	
<p>5. PLACE OF BIRTH Baltimore, Maryland</p>		<p>6. OCCUPATION None</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. EDUCATION High School</p>	
<p>9. RACE White</p>		<p>10. RELIGION Methodist</p>	
<p>11. DATE OF DEATH 1945</p>		<p>12. TIME OF DEATH 10:00 AM</p>	
<p>13. PLACE OF DEATH Home</p>		<p>14. CAUSE OF DEATH Heart Disease</p>	
<p>15. MEDICAL HISTORY None</p>		<p>16. SURVIVAL OF DEATH None</p>	
<p>17. SIGNATURE OF DECEASED James L. Thompson</p>		<p>18. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>19. SIGNATURE OF DECEASED James L. Thompson</p>		<p>20. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>21. SIGNATURE OF DECEASED James L. Thompson</p>		<p>22. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>23. SIGNATURE OF DECEASED James L. Thompson</p>		<p>24. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>25. SIGNATURE OF DECEASED James L. Thompson</p>		<p>26. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>27. SIGNATURE OF DECEASED James L. Thompson</p>		<p>28. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>29. SIGNATURE OF DECEASED James L. Thompson</p>		<p>30. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>31. SIGNATURE OF DECEASED James L. Thompson</p>		<p>32. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>33. SIGNATURE OF DECEASED James L. Thompson</p>		<p>34. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>35. SIGNATURE OF DECEASED James L. Thompson</p>		<p>36. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>37. SIGNATURE OF DECEASED James L. Thompson</p>		<p>38. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>39. SIGNATURE OF DECEASED James L. Thompson</p>		<p>40. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>41. SIGNATURE OF DECEASED James L. Thompson</p>		<p>42. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>43. SIGNATURE OF DECEASED James L. Thompson</p>		<p>44. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>45. SIGNATURE OF DECEASED James L. Thompson</p>		<p>46. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>47. SIGNATURE OF DECEASED James L. Thompson</p>		<p>48. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>49. SIGNATURE OF DECEASED James L. Thompson</p>		<p>50. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>51. SIGNATURE OF DECEASED James L. Thompson</p>		<p>52. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>53. SIGNATURE OF DECEASED James L. Thompson</p>		<p>54. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>55. SIGNATURE OF DECEASED James L. Thompson</p>		<p>56. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>57. SIGNATURE OF DECEASED James L. Thompson</p>		<p>58. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>59. SIGNATURE OF DECEASED James L. Thompson</p>		<p>60. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>61. SIGNATURE OF DECEASED James L. Thompson</p>		<p>62. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>63. SIGNATURE OF DECEASED James L. Thompson</p>		<p>64. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>65. SIGNATURE OF DECEASED James L. Thompson</p>		<p>66. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>67. SIGNATURE OF DECEASED James L. Thompson</p>		<p>68. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>69. SIGNATURE OF DECEASED James L. Thompson</p>		<p>70. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>71. SIGNATURE OF DECEASED James L. Thompson</p>		<p>72. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>73. SIGNATURE OF DECEASED James L. Thompson</p>		<p>74. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>75. SIGNATURE OF DECEASED James L. Thompson</p>		<p>76. SIGNATURE OF WITNESS James L. Thompson</p>	
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<p>79. SIGNATURE OF DECEASED James L. Thompson</p>		<p>80. SIGNATURE OF WITNESS James L. Thompson</p>	
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<p>87. SIGNATURE OF DECEASED James L. Thompson</p>		<p>88. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>89. SIGNATURE OF DECEASED James L. Thompson</p>		<p>90. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>91. SIGNATURE OF DECEASED James L. Thompson</p>		<p>92. SIGNATURE OF WITNESS James L. Thompson</p>	
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<p>95. SIGNATURE OF DECEASED James L. Thompson</p>		<p>96. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>97. SIGNATURE OF DECEASED James L. Thompson</p>		<p>98. SIGNATURE OF WITNESS James L. Thompson</p>	
<p>99. SIGNATURE OF DECEASED James L. Thompson</p>		<p>100. SIGNATURE OF WITNESS James L. Thompson</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12390

12403

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			
c. LENGTH OF STAY IN 1b 10 years				d. STREET ADDRESS Denton Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Denton Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harrison Middle Henry Last Trice				4. DATE OF DEATH Month November Day 2 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1888		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Trice				14. MOTHER'S MAIDEN NAME Martha Rosser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-30-8984		17. INFORMANT Mrs. Ralph D. Lord, Federalsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myastatic Carcinoma of Brain 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Adeno Carcinoma Lung DUE TO (c) July 21, 59						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21-1959 to Nov-2-1959 , that I last saw the deceased alive on Nov. 2-1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Lennon M.D.				ADDRESS (Street, city or town, state) Federalsburg Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) W. E. Lennon MD				Federalsburg Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR NOV 5 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Himes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TWIN BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	